

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

CERTIFICATE OF DEATH

 10031
 ★ Reg. Dist. No. 106

1. PLACE OF DEATH:

County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

B.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Cremation Date thereof Oct 24 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. 10/23 1945 Odey Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... October 21 1945 at 7:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to Oct 1945 and that I last saw him alive on Oct 1945Immediate cause of death.....
Ac. Coronary Disease of Heart

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address..... Date signed Oct. 22 1945

RECEIVED

NOV 2 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

10032

Reg. Diat. No. 106

1. PLACE OF DEATH:

County CharlesCity or town Indian Head
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Perry Wright project

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County CharlesCity or town Indian Head
(If outside city or town limits, write RURAL and give nearest town)Street No. Perry Wright project
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Johanna Agnes Goyer

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FemaleNegroSingle

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1940

8. AGE:

Years

Months

Days

If less than one day

5

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

child

11. Industry or business

FATHER MOTHER

12. Name

George Goyer

13. Birthplace

Waldorf, Md

14. Maiden name

Mary Agnes Thomas

15. Birthplace

Indian Head, Md

16. Informant

Address

Indian Head, Md.

17.

Burial

(Burial, cremation, or removal, which?)

Date thereof

10/17/45

Cemetery or crematory

St. Charles

Location

Glennmont, Md

18. Funeral director

Address

Waldorf, Md.

19.

10/18
(Date rec'd by registrar)

1945

Odey Price

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1945, at 10:07 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on

Oct. 15, 1945, to 19and that I last saw him on Oct. 15, 1945

Immediate cause of death

Multiple traumatic amputation

DURATION

47'

Due to

Railroad accident47'

Due to

Struck by train

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10.15.45Where did injury occur? Indian Head, Charles, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) RR crossingMeans of injury Struck by train Injured at work? No

23. SIGNATURE

J. Mackenbach, M.D.

M. D. or other

Address

Indian Head, Md.Date signed 10.18.45

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NOV 2 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1792

CERTIFICATE OF DEATH

10033

Reg. Dist. No. 100

1. PLACE OF DEATH:

County..... Charles
 City or town..... La Plata
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... one week
 Hospital, institution, or street address where death occurred:
Physicians Memorial Hospital
 How long in hospital or institution?..... one week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... md. County..... Charles
 City or town..... Dublin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Joanna DePew

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... January 19, 1945
 8. AGE: Years..... Months..... Days..... It less than one day..... hrs. min.

9. Birthplace..... Chas Co. Md.
 (Town, county, and state)
 10. Usual occupation..... Infant
 11. Industry or business.....
 12. Name..... Enory DePew
 13. Birthplace..... Hancock Co., Tenn.
 14. Maiden name..... Amanda Pennington
 15. Birthplace..... Leslie Co., Ky.

16. Informant..... Thos. DePew (w/le)
 Address..... La Plata, Md.
 17. Burial Date thereof..... Oct. 14, '45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Methodist Church Cndy
 Location..... Dentsville, Md.
 18. Funeral director..... Huntt & Ryan
 Address..... Waldorf, Md.
 19. 10-13-45 19.....
 (Date rec'd by registrar) Registrar Julia H. Posey

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Oct. 13, 1945 at 7:48 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct. 6, 1945, to Oct. 13, 1945
 and that I last saw her alive on Oct. 13, 1945

Immediate cause of death..... Chronic pancreatitis DURATION..... 2-3 months

Due to..... Repeated attacks of acute DURATION..... 6-7 months
enteritis (non-infectious)

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... James L. MacKinnon, M.D. M.D. or other
 Address..... La Plata, Md. Date signed..... 10-13-45

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OCT 19 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89-2

CERTIFICATE OF DEATH

10034

★ Reg. Dist. No. 100

1. PLACE OF DEATH:
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Ann C Garner

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W

6. (b) Name of husband or wife Joseph Edward Garner
B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Aug 17, 1869

8. AGE: Years 76 Months 2 Days 10 If less than one day
..... hrs. min.

9. Birthplace Charles Co
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name H. Elsh

13. Birthplace

14. Maiden name Susanna Farrell

15. Birthplace

16. Informant Joseph Allison Garner

Address Beltsville Md.

17. Burial Date thereof 10-30-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph

Location Poolesville MD

18. Funeral director Hunt & Ryan

Address Waldorf MD

19. 10-29 19-45
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1945 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1941 to Oct 27 1945
and that I last saw h. e. R. alive on Oct 26 1945

Immediate cause of death Cerebral Hemorrhage
DURATION 10-24-45

Due to Generalized Arteriosclerosis
1935

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operation..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. J.
Address Latrobe Md. Date signed 10-28-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

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NOV 1 1945

BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 105-

1. PLACE OF DEATH:

County..... Charles
 City or town..... White Plains md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md County..... Charles
 City or town..... White Plains md
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Joseph Harley

3. (b) Social Security Number

4. Sex..... m 5. Color or race..... C 6.(a) Single, married, widowed, or divorced..... married

8.(b) Name of husband or wife..... Mary

7. Birth date of deceased (mo., day, yr.)..... May 1-1883 6.(c) If alive, give age..... years

8. AGE: Years..... 62 Months..... 5 Days..... 17 If less than one day..... hrs. min.

9. Birthplace..... Charles Co md
 (Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business

12. Name..... Richard Harley
 13. Birthplace..... Open Hill md

14. Maiden name..... Roseann Harley
 15. Birthplace..... Open Hill md

16. Informant..... Mary Harley
 Address..... White Plains md

17. Burial..... Date thereof..... 10-20-45
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St Ignace
 Location..... Bel Air md

19. Funeral director..... Smith & Ryan
 Address..... Malden md

19. 10-19-45 19. 45 M C MOKER
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Oct 18 19. 45 at 12:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 8 19. 45 to OCT 18 19. 45
 and that I last saw him alive on 10-16-45 19.

Immediate cause of death..... Chronic myelocytic
 DURATION..... 3 yr

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... Ernest J. J. M. D.Address..... Bel Air md M. D. or otherDate signed..... 10-18-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD EXAMINATION

RECEIVED
OCT 26 1945
BUREAU V.R.

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10036

Reg. Dist. No. 106

1. PLACE OF DEATH:

County Charles
City or town Rural (Ripley)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Charles
City or town Rural Ripley
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Joseph William Long

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Ada T. Long

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1876 8. (c) If alive, give age 68 years

8. AGE: Years 69 Months 1 Days 4 If less than one day

9. Birthplace Nanjemoy, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own Farm

12. Name Joseph Long

13. Birthplace Ireland

14. Maiden name Not Known

15. Birthplace

16. Informant Philip Thomas Long

Address 710 Washington St. N.W.

17. Burial Oct. 20 1945

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Nanjemoy Baptist Church

Location Nanjemoy, Md.

18. Funeral director Waldorf, Md.

Address

19. 10/22 HS Oliver Price

(Date rec'd by registrar) Registrar

(Assumed) MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1945 at 10:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death Coronary Occlusion DURATION 1 day

Deceased was last seen live October 12, 1945.

Death was assumed to have taken place P.M. Oct. 12.

but body not discovered until P.M. Oct. 18, 1945.

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank G. Susan

Address 1214 N. Wood St. M. D. or other

Date signed 12/19/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 2 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH: *C. Walters*
 County.....
 City or town.....*Waldorf Md*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....*Md* County.....*Ches*
 City or town.....*Waldorf Md*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Oellie B. Luna

3. (b) Social Security Number

4. Sex.....*F* 5. Color or race.....*N* 6. (a) Single, married, widowed, or divorced.....*Wid*

6. (b) Name of husband or wife.....*Lunford*

7. Birth date of deceased (mo., day, yr.).....*Nov 2 - 1872* 8. (c) If alive, give age.....years

8. AGE: Years.....*72* Months..... Days..... If less than one day.....hrs.min.

9. Birthplace.....*Tenn*
 (Town, county, and state)

10. Usual occupation.....*Housewife*

11. Industry or business

12. Name.....*James Butler*

13. Birthplace.....*Miss*

14. Maiden name.....*Lucinda M. L. L. L.*

15. Birthplace.....*Tenn*

16. Informant.....*Lucy Winkler*

Address.....*Waldorf Md*

17. Burial, cremation, or removal, Which?.....*Burial* Date thereof.....*Oct 28, 1945*
 (month) (day) (year)

Cemetery or crematory.....*St Paul*

Location.....*Waldorf*

18. Funeral director.....*Smith & Roy*

Address.....*Waldorf Md*

19. Date rec'd by registrar.....*Oct 26/45* Registrar.....*M. L. Med...*

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Oct 25 -* 19*45*, at.....*Waldorf Md*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*Jan* 19*40*, to.....*Oct 28* 19*45*, and that I last saw him alive on.....*10/1/45* 19*45*

Immediate cause of death.....*Cancer*

Due to.....*De compensation*

Due to.....*Carcinomatosis*

Due to.....*Pulmonary*

Other conditions.....*Metastasis*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22-VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

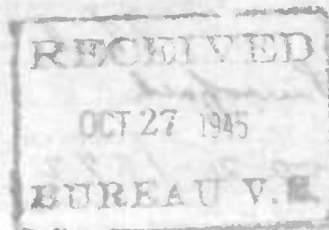
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....*W. D. Winkler, M.D.* M. D. or other

Address.....*Waldorf Md* Date signed.....*10/26/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

10038

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County..... **Charles**
 City or town..... **Benedict**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **40 years**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... **Maryland** County..... **Charles**
 City or town..... **Benedict**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

FRANCES IRENE MESSICK3. (b) Social Security Number
none

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Married	
6. (b) Name of husband or wife..... Harry G. Messick			
7. Birth date of deceased (mo., day, yr.) Nov. 19 1880			
8. AGE: Years 64	Months 10	Days 28	6. (c) If alive, give age..... 68 years hrs. min.

9. Birthplace..... **St. Marys Co., Md**
 (Town, county, and state)
Housewife

10. Usual occupation.....

11. Industry or business.....

FATHER	12. Name..... Eli Copsey
	13. Birthplace..... St. Mary's Co., Md
MOTHER	14. Maiden name..... Zola Ann Wood
	15. Birthplace..... St. Mary's Co., Md

16. Informant..... **Harry G. Messick**
 Address..... **Benedict**

17. **Burial** Date thereof..... **10-16-45**
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... **Old Field's**
 Location..... **Hughesville, Md.**

18. Funeral director..... **Elmer M. Quade**
 Address..... **Hughesville, Md.**

19. **10-15** 19 **45**
 (Date rec'd by registrar) Registrar..... **Julius H. Pacey**

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **October 14** 19 **45** at **7.10 P** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **July 13/45** 19 to **Oct 14/45** 19
 and that I last saw h..... alive on **Oct 13/45** 19

Immediate cause of death..... **Cerebral Hemorrhage, 3 mo.**
 Due to..... **Arteriosclerotic hypertension with brain**
 Due to..... **Tobacco Pneumonia** **2 days**

Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... **Samuel D. Fisher** M. D. or other
 Address..... **Hughesville** Date signed..... **10/15/45**

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OCT 19 1945

BUREAU V S

2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of name of child is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10039

Reg. Dist. No. 100

FILM No. I 04 JUN 12 1946

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him

Immediate cause of death

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE

Address

DURATION

Birth

6 mos

Plumtree

Date of op.

M. D. or other

Date signed

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NOV 9 1945

BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH:

County Charles
City or town Back Point
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:

Slay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Charles
City or town Back Point Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Josephine Whittington

3. (b) Social Security Number

4. Sex F. 5. Color of race B 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife John H. Whittington

6(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 66 Months - Days - If less than one day - hrs. - min.

9. Birthplace Charles Co., Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Butler

13. Birthplace unknown

MOTHER 14. Maiden name Lucenia Beath Hawkins

15. Birthplace unknown

16. Informant John H. Hawkins

Address Bushwood

17. Burial Date thereof 10-11-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Ghost

Location Back Point, Md.

18. Funeral director Wm. H. Hays

Address Nalden

19. 10-10- 19 45 William Hays
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9- 19 45, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-6- 19 45, to 10-9- 19 45, and that I last saw her alive on 10-9- 19 45.

Immediate cause of death

apoplexy

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE J. E. Hays M. D. or other

Address Nayside Date signed 10-10-45

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 12 1945

BUREAU V. S.